Treatment refractory mood disorders: Case report

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KEYWORDS

depression, treatment refractory, bipolar disorder

CASE

BF is a 42 year-old Caucasian male who reported his onset of depression began four years ago after he was involved in a car accident that fractured his hip. He was not treated for depression until he overdosed on approximately 50 aspirin 325 mg tablets and 750 ml of whiskey (seven months following the accident). After being medically cleared from the emergency room and acute inpatient unit, he was transferred to inpatient psychiatry for evaluation of depression. Upon admission to the inpatient psychiatric unit, his labs were found to be within normal limits (WNL) except a slight elevation in gamma-glutamyl transferace (GGT) at 51 U/L, likely from his acute alcohol ingestion. His thyroid panel was also WNL. He denied any other illness or taking any other medications.

BF was diagnosed with major depressive disorder (MDD) and started on escitalopram while on the inpatient unit, which he felt was "somewhat helpful" for his depression after approximately two weeks, but was unable to continue taking it when he lost his insurance two weeks post-discharge and could not afford to pay out-of-pocket for it. He was lost to follow-up for 12 months when he contacted the Mood Disorders outpatient clinic complaining of depression with some passing suicidal thoughts with no plan or intent.

He was able to find employment, but felt his job was in jeopardy since he had poor energy, inability to complete his tasks at work, social isolation and irritability. He stated that he was sleeping more and would wake depressed, but his mood would slowly improve as the day progressed. He denied any alcohol, illicit drug or tobacco use. He reported his mother also had depression but was not receiving treatment for it. He also had a maternal uncle with bipolar II disorder. He denied any physical illnesses and reported that he recovered fully from his hip fracture.

He was started on sertraline 50 mg orally every morning but had to stop after two weeks because it made him feel "wired." He was switched to citalopram 10 mg orally every morning for 7 days, then 20 mg orally every morning, but stopped after a month, reporting that it made him feel anxious. He was switched to mirtazapine 15 mg orally at bedtime, but was unable to increase beyond 15 mg due to excessive sedation the next day. He denied any anxiety as he had with citalopram, but continued to report on-going depression. After one month, he was given a trial of aripiprazole 5 mg orally every morning, but stopped after four doses as he reported, "it made me feel like I'm crawling out of my skin." At this time he also reported he was unable to sleep and felt restless and irritable. Both his mirtazapine and aripiprazole were stopped and he was given quetiapine 50 mg orally at bedtime to help with poor sleep, irritability and restlessness. He reported improved sleep on quetiapine but his mood was still irritable. During his last clinic visit, he was noted to be more talkative than at previous visits and described racing thoughts. He admitted to feeling distracted and unable to complete multiple projects he started at home, which caused further agitation. His quetiapine dose was increased to 100 mg, but he felt "over medicated and groggy" the next day and self-reduced back to 50 mg at bedtime.

CURRENT VISIT

Frustrated, BF stopped all medications two days after his last visit, which was 28 days ago. He continued to feel irritable and anxious, "snapping at people all the time." He continued to feel "flighty" with racing thoughts and rapid speech. He stated he was still not sleeping much, but doesn't feel tired the next day. He stated his mood is depressed and feels hopeless about the situation. He has had some passing suicidal thoughts but no plan or intent. He denied drugs or alcohol use and had a negative urine toxicology screen. His other labs were all within normal limits.

DIAGNOSIS

According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), BF meets criteria for bipolar II disorder.[1] If an antidepressant causes a switch into hypomania or mania, and persists beyond the physiological effect of the medication, the patient can be

considered bipolar.[1] BF has both depressive symptoms (depressed mood, hopelessness, poor sleep, recurrent thoughts of death) as well as hypomanic symptoms (hyperverbal, racing thoughts, decreased need for sleep), which continues despite being off all psychotropic medications for approximately four weeks. Due to his poor response to antidepressants, presence of both depression and hypomania occurring simultaneously, his diagnosis was changed to bipolar II disorder, depressive episode with mixed features.

UNIPOLAR VS. BIPOLAR DEPRESSION

As most people with bipolar disorder experience depression rather than mania as their first episode of illness, misdiagnosis of bipolar II disorder as a major depressive episode is common.[2] A study was conducted comparing symptom commonality evaluating subjects with bipolar I disorder (n=443) to recurrent MDD (n=593). Characteristics that best predicted bipolar rather than unipolar depression were the presence of psychosis, diurnal mood variation and hypersomnia during mood episodes. Subjects that had bipolar disorder reported a greater number of depressive episodes, but of shorter duration than those with MDD. Subjects with unipolar depression more often had excessive self-reproach, loss of energy, and diminished libido (Table 1).[3]

Table 1: Lifetime characteristics predicting bipolar vs. unipolar depression[2]

	MDD	Bipolar Disorder	p-value
Participants (n=1036)	593	443	
Number of depressive episodes	2 %	6 %	0.006
Length of longest episode	60 weeks	29 weeks	<0.001
Symptoms present during depression			
Psychotic features	10.5 %	30.2 %	<0.001
Diurnal Mood Variation	50.4 %	59 %	0.030
Excessive Self-Reproach	96.2 %	87.7%	0.000
Loss of Energy	99.2 %	95.5 %	0.050
Hypersomnia	21.5 %	42.8 %	0.001
Diminished libido	63.5 %	34.8 %	<0.001

CASE CONTINUED

BF was started on lithium 300 mg orally twice daily and an appointment set for four weeks. At his four week follow-up visit, BF reported that his irritability had significantly decreased. He was no longer as talkative or restless as he had been at previous visits. His sleep had improved and his mood was slowly improving. His lithium level at this visit was 0.61 mEq/L.

CONCLUSION

Patients presenting with depression that do not respond to multiple antidepressant treatment trials at sufficient doses and for an adequate length of time, are considered treatment-resistant.[4] Many times, these patients may actually have undiagnosed bipolar disorder and are in a depressive episode. These patients may often present with more hypersomnia and have shorter yet more frequent episodes than those patients who do not have bipolar disorder. In this case, BF presented with diurnal mood and hypersomnia which are more commonly seen in bipolar depressed patients. BF also had multiple antidepressant failures and became irritable and was easily distractible with racing thoughts while on antidepressants. These symptoms persisted even after removal of the medications, which changed his diagnosis from depression to bipolar disorder. Although he was prescribed two medications, aripiprazole and quetiapine, which can be considered for bipolar disorder, he was not able to tolerate either medication.

Careful review of symptoms and past medication trials as well as information on family members is essential for appropriate diagnosis and treatment for these patients. As with this case, a trial of a mood stabilizer or atypical antipsychotic with efficacy for bipolar depression might be warranted. Lithium was dosed to response with levels within the considered therapeutic range.[5]

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